DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

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I have made the suggested changes, but see a few problems with the draft as is.

Even though "dental plan" is a defined term and means an insurance plan, it is not clear that "plan that provides coverage for dental and related services" is something different from a "dental plan." It is at least confusing. Since "plan that provides coverage for dental and related services" is intended to apply to both insured and self−funded plans, it would be possible to use that term (or "policy or plan that provides coverage for dental and related services") throughout the draft and not define or use "dental plan." The only place in the draft where "dental plan" is used currently is in proposed s. 632.873 (2) (a), and that paragraph specifically states that the contract is between an insurer and a dentist, so using a term that is defined as an insurance policy is not necessary for the proper meaning.

The other problem is with applying the provisions to self−funded plans or third−party administrators of self−funded plans. ERISA (the federal Employee Retirement Income Security Act) preempts state regulation of self−funded plans. A state may not enact any law that "relates to" an employee benefit plan (or employer's uninsured, or self−funded, plan). In my opinion, proposed sub. (2) (b) could be determined to relate to an employee benefit plan to such an extent that it would be preempted. I assume that the only reason a dentist would comply with a requirement related to what fees he or she may charge for services that are *not* covered services under a self−funded plan (and therefore really no business of the third−party administrator's) is because that is a requirement for being in the provider network. Specifying what a third−party administrator may not do with respect to a self−funded plan's provider network "relates to" an employee benefit plan. See 80 OAG 290 (1992) for an attorney general's opinion that the commissioner of insurance lacks authority to regulate administrators under ch. 633 because of ERISA preemption.

Regarding the change from "normal fee" to "nondiscounted fee" in proposed sub. (3), should it say something like "*usual* nondiscounted fee"? Saying that a dentist may not charge more than the dentist's nondiscounted fee is sort of a tautology, like saying the dentist may not charge more than what he or she charges. Unless there are universal, standard charges for dental services, a dentist could charge *any* amount and not discount it and that would be the nondiscounted charge.

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